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In the Supreme Court of the United States

OCTOBER TERM, 1997

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS

v.

DELORES SCOTT SULLIVAN, ET AL., RESPONDENTS

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

REPLY BRIEF FOR PETITIONERS

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REPLY BRIEF FOR PETITIONERS

While respondents labor to portray this case as a "parochial dispute" affecting only the Commonwealth of Pennsylvania (Opp. 7), the practical and doctrinal significance of the decision below cannot seriously be denied. Respondents do not (and cannot) deny that at least 43 states, and the federal government, have cost containment measures similar, if not identical, to the utilization review procedure at issue in this case. See Pet. 15 n.6, 24-25. Nor do they dispute that the Third Circuit's decision renders that procedure all but useless, and effectively transfers regulatory authority over workers' compensation insurance from state legislatures to federal courts. Their attempts to distinguish conflicting lower court cases border on the frivolous. In short, respondents' brief confirms that this case warrants Supreme Court review.

I. THE STATE ACTION ISSUE

A. *The Merits*. We will not respond in detail to respondents' argument on the merits (Opp. 10-15). It rests largely on the dubious proposition that payments by a private insurance company to satisfy the legal obligations of a private employer to its injured workers are, in fact, "public benefits" akin to welfare or Social Security. See *id.* at 5, 7, 8-9, 13, 14; see also *id.* at 14 n.8 (referring to the Commonwealth's "constitutional and statutory duty to provide benefits"). The fallacy in that characterization was explained in the Petition (at 10-11): workers' compensation benefits are *mandated by the state*, but they are not *obligations of the state*. For state action purposes, they are analogous to insurance payments to satisfy a private party's tort liability. Indeed, it is precisely because the Third Circuit has obliterated the fundamental distinction between a system of benefits funded and distributed by the government and a system of regulated private benefits that the decision below warrants review.

It is telling that respondents do not even attempt to refute our showing (Pet. 12-14) that the decision below conflicts with this Court's decisions in *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974); *Blum* v. *Yaretsky*, 457 U.S. 991 (1982); and *Rendell-Baker* v. *Kohn*, 457 U.S. 830 (1982). In fact, they neglect to mention *Jackson* or *Rendell-Baker*. They include *Blum* in a string

cite, with no attempt to distinguish it (Opp. 11). We take it, then, that respondents concede the conflict with these three precedents.

Rather than addressing these conflicts, respondents rely on the proposition that this Court has not prescribed any "formulaic and rigid approach to state action" and that state action decisions are necessarily "fact-bound." Opp. 11-12. But the necessarily fact-bound context of state action issues does not imply that lower courts are free to dispense with any rigorous analysis. If that were true, this Court should never grant certiorari in any state action case. Respondents' only attempt to provide an analytical structure for the state action question (*id.* at 12) is based on a three-part test extracted from this Court's decision in *Edmonson* v. *Leesville Concrete Co.*, 500 U.S. 614 (1991), *on which the Third Circuit did not rely*. That is tantamount to confessing that the Third Circuit offered "no coherent theory of state action" to justify its decision (see Pet. 12). As we stated in the Petition, this Court's review is needed to bring greater clarity and coherence to this important area of constitutional law. The Brief in Opposition unintentionally confirms the need for that guidance.

B. *Conflicts Among The Lower Courts*. In the Petition, we documented direct conflicts on the state action question with four federal courts of appeals as well as the state courts of Pennsylvania. Pet. 14-20. Respondents call this "baseless" (Opp. 15) and an "attempt to fabricate a conflict" (*id.* at 6). Yet their reasons are as weak as their rhetoric is strong.

First, noting that three of the four federal appellate decisions that conflict with the decision below were unpublished, respondents assert that it is "highly improper to argue that [unpublished decisions] establish a conflict in the circuits that warrants this Court's review." Opp. 16. Far from being "highly improper," however, this is in accord with this Court's practice. Cases in which this Court has granted certiorari to resolve conflicts involving unpublished opinions are legion. Recent examples include: *Commissioner* v. *Lundy*, 516 U.S. 235, 238-39 (1996); *Wooddell* v. *Int'l Bhd. of Elec. Workers*, 502 U.S. 93, 96 & n.2 (1991); *Wisconsin Pub. Intervenor* v. *Mortier*, 501 U.S. 597, 604 (1991); *Exxon Corp.* v. *Central Gulf Lines, Inc.*, 500 U.S. 603, 606-07 & n.4 (1991); *Lytle* v. *Household Mfg., Inc.*, 494 U.S. 545, 550 & n.2 (1990); *Doe* v. *United States*, 487 U.S. 201, 206 n.4 (1988); *Kentucky* v. *Graham*, 473 U.S. 159, 163 & n.6 (1985).

Second, they argue that, "[b]y definition," there "can be no conflict among the circuits in a case such as this" (Opp. 7) because the decisions arise under the workers' compensation laws of different states. This argument obviously proves too much: if it were true, this Court would never grant certiorari in a case involving the constitutionality of a state law. State laws are always different.

The real question is whether the state laws under review in these cases are different in any material respect. The state laws in all of the cases share a crucial characteristic: they authorize private insurance companies (and self-insured employers) to postpone payment of disputed workers' compensation bills until after investigation to determine whether the expense was legitimate. In all cases, this delay was permitted, but neither encouraged nor required, by the state. That is why the district court discussed and relied on all three of the four decisions that had been rendered by the time of its opinion, finding no significant points of distinction (Pet. App. 56a-58a).

If respondents wish to contend that the conflict is "baseless," they are under an obligation to identify differences in the statutory schemes that would produce a different result. This they fail to do. As to two of the decisions — *Grenz* v. *EBI/Orion Group, Inc.*, 1992 WL 158158 (9th Cir. July 9, 1992), and *Fleming* v. *Workers' Compensation Comm'n*, 1996 U.S. App. LEXIS 3858 (4th Cir. Mar. 5, 1996) — respondents do not even attempt to identify any relevant difference. Their purported distinctions of the other two decisions do not withstand analysis.

Respondents suggest (Opp. 17 n.12) that *Stanescu* v. *Aetna Life and Casualty Ins. Co.*, 1996 WL 466648 (2d Cir. Aug. 16, 1996), "cannot be seriously compared to *Sullivan*" because (1) "the injured workers in that case relied solely upon the exclusivity of workers' compensation for work injuries in Connecticut as their predicate for state action" and (2) "there was no interdependence between the insurers and the state and there was no state review of any kind." Neither point is correct. First, as the Second Circuit

pointed out, the workers in *Stanescu* invoked not just exclusivity but "joint participation" between the insurer and the State as a basis for finding state action. 1996 WL 466648, at *2. They also argued that the insurer was a state actor because it "was subject to pervasive State regulation pursuant to the Workers' Compensation Act and because [it] intentionally used the procedures established under that regulatory scheme to deny [the plaintiffs] workers' compensation benefits and medical treatment." *Stanescu* v. *Aetna Life and Casualty Ins. Co.*, No. 3:95CV356, slip op. 4 (D. Conn. Dec. 13, 1995). Second, there was no less "interdependence" between the insurer and the state in *Stanescu* than in this case. To suspend payments under the provision of Connecticut law at issue in *Stanescu*, the insurer was required to file a report containing "all information supporting [its] claim" with a state agent, who had authority to accept or reject it. Conn. Gen. Stat. § 31-349 (West 1995). If anything, this suggests a *greater* degree of state involvement than in this case, where the insurer's filing with the state is reviewed only for formal completeness.

Respondents summarize the Third Circuit's purported reasons for distinguishing *Barnes* v. *Lehman*, 861 F.2d 1383 (5th Cir. 1988). Opp. 17 n.13. But as we discussed in detail in the Petition (at 16-17), these purported differences were "either based on a misunderstanding of Texas law or irrelevant to the state action issue." Respondents do not even attempt to respond to our arguments.

Respondents maintain that the conflict between the Third Circuit and the state courts of Pennsylvania has disappeared because a subsequent decision of the Pennsylvania Supreme Court contained language seemingly at odds with the earlier decision. Opp. 18 n.14. The later case, *Bible* v. *Commonwealth of Pennsylvania*, 696 A.2d 1149 (Pa. 1997), however, did not involve a state action issue. The question presented in *Bible* was whether retroactive changes in workers' compensation benefit amounts violate the state constitution's equivalent of the Contracts Clause. The court held that they do not, because the benefit levels are not contractual in nature. That holding has no bearing on whether the actions of private insurance companies within the discretion left to them under the statutory scheme should be deemed to be state action. The conflict between the state courts and the Third Circuit created

by *Baksalary* v. *Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), appeal dismissed, 469 U.S. 1146 (1985), and deepened by the Third Circuit's decision below, still exists. Pennsylvania decisions subsequent to *Baksalary* have, perforce, acknowledged the authority and effect of the federal ruling, but have not accepted the correctness of its reasoning on the state action question or applied that reasoning to other contexts.[1]

C. *Practical and Doctrinal Significance*. The Third Circuit's state action holding is of doctrinal importance far beyond the context of workers' compensation. The Third Circuit's logic — that private insurers become state actors when they are subject to extensive regulation, a mandate to provide benefits, state dispute resolution, and filing requirements — could apply to a wide range of benefit plans regulated at the federal or state level,[2] as well as a host of other regulated industries in which the government mandates service.

II. THE DUE PROCESS ISSUE

As we explained in the Petition, the due process holding of the court below would overturn the law and traditional practice of almost every state and the federal government, would make it extremely difficult to protect against fraud and abuse by medical providers, and would cast doubt on the constitutionality of utilization review in a wide variety of contexts. Respondents do not

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[1] See, *e.g.*, *Williams* v. *Workmen's Compensation Appeal Bd.*, 562 A.2d 437, 439 n.3 (Pa. Commw. Ct. 1989); *Kinter* v. *Workmen's Compensation Appeal Bd.*, 579 A.2d 1010, 1011 n.2 (Pa. Commw. Ct. 1990); *Moore* v. *Workmen's Compensation Appeal Bd.*, 676 A.2d 690, 694 (Pa. Commw. Ct. 1996); *Warminster Fiberglass* v. *Workers' Compensation Appeal Bd.*, 708 A.2d 517, 519-20 n.4 (Pa. Commw. Ct. 1998).

[2] See, *e.g.*, *Grijalva* v. *Shalala*, ___ F.3d ___, 1998 WL 467102, *4 (9th Cir. Aug. 12, 1998) (concluding, based on reasoning similar to that adopted by the Third Circuit, that HMOs administering Medicare benefits are state actors); *Kreschollek* v. *Southern Stevedoring Co.*, Civ. No. 93-9303, slip op. 5-7 (D.N.J. Sept. 30, 1997) (applying a similar analysis and holding that self-insured employers paying benefits under the federal Longshore and Harbor Workers' Compensation Act are state actors).

dispute any of these points. The arguments they do make, moreover, are wholly without merit. We will discuss those that pertain to our petition in the order presented.

A. *Mootness*. First, respondents contend that the due process issue is moot because the Commonwealth has already modified its procedures to rectify the supposed due process problem and is not seeking review of the opinion below. Opp. 18-19. In fact, the Commonwealth filed a conditional cross-petition challenging the due process holding on July 10, 1998. Counsel for respondents were well aware when they wrote the Brief in Opposition that the Commonwealth intended to file the cross-petition, having been informed of that fact by counsel for the Commonwealth as well as by counsel for these petitioners.

Even if the Commonwealth had not filed a petition for certiorari, respondents' mootness argument would still be erroneous. Although respondents are correct that the Pennsylvania Bureau of Workers' Compensation has modified the forms required to initiate utilization review, and thus satisfied the requirements of the decision below that pertain to notice, petitioners have not sought review of that aspect of the Third Circuit's decision. Pet. 22 n.12. The petition is confined to the most significant issue in the case: the right of insurers (and self-insured employers) to postpone payment of disputed claims pending utilization review. The Third Circuit struck from the statute the authorization for delay of payment in disputed cases, Pet. App. 25a,[3] and no action by the Bureau could possibly render that portion of the decision moot. Furthermore, the petitioners are still subject to respondents'

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[3] The statute, in the form passed by the legislature, provided in relevant part:

> All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records *unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6).*

77 Pa. Cons. Stat. Ann. § 531(5) (West 1997) (emphasis added). The Court of Appeals severed the italicized portion of the statute, leaving insurers with the obligation to pay disputed claims before utilization review could take place.

claims for damages and injunctive relief based on the Third Circuit's ruling.

B. *Conflicts With* Doehr *And Among The Lower Courts*. In the Petition, we showed that the decision below was inconsistent in two important respects with this Court's decision in *Connecticut* v. *Doehr*, 501 U.S. 1 (1991). First, *Doehr* held that analysis of due process requirements must be informed by a review of "[h]istorical and contemporary practices." *Id.* at 16-17.[4] Respondents' cursory denial (Opp. 28 n.20) that *Doehr* requires this reference to established practices ignores the express directive in that case. The Third Circuit's opinion flagrantly violates that principle, by failing to give the practices of Pennsylvania and virtually all other states any weight in its analysis.

Second, *Doehr* held that in a case involving disputes between private parties, the standard due process analysis must be altered to take the interests of *both* private parties into account (rather than just the plaintiff's interest and the governmental interest). 501 U.S. at 10-11. Even though it acknowledged the insurers' argument that their property interest must also be considered (Pet. App. 27a), the Third Circuit then conducted the due process balancing test without reference to the private interests of the employers or insurers, in violation of the teaching of *Doehr*. See *id.* at 28a (concluding that "the employees' private interest" is "a weighty and significant factor in the * * * calculus" without mentioning the insurers' interest); *id.* at 30a (concluding that "the private interest" of employees is not outweighed by "any governmental interest," again without mention of any other private interest). Respondents thus mischaracterize the holding below as taking insurer interests into account. The lower court's failure to do so was especially significant since, by law, an insurer can never recover payments once made to a provider and thus irrevocably forfeits its property interest.

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[4] That was not a novel holding. See, *e.g.*, *Burnham* v. *Superior Court*, 495 U.S. 604, 621-22 (1990) (opinion of Scalia, J.); *Schall* v. *Martin*, 467 U.S. 253, 268 (1984); *In re Winship*, 397 U.S. 358, 361-62 (1970); *Leland* v. *Oregon*, 343 U.S. 790, 798 (1952).

Respondents have even less of relevance to say about the conflicts with other federal courts of appeals. See Opp. 29 n.24. To be sure, in *Cryder* v. *Oxendine*, 24 F.3d 175 (11th Cir. 1994), and *Sauceda* v. *Dep't of Labor & Indus.*, 917 F.2d 1216 (9th Cir. 1990), the injured workers received more notice that the insurers were delaying payment of bills pending further review (see Opp. 29 n.24). But the issue here is not the Third Circuit's notice requirement — which petitioners are not contesting — but the separate requirement that provider bills be paid before utilization review. The relevant conflict is that in *Cryder* and *Sauceda*, the Eleventh and Ninth Circuits held that it does not violate due process for workers' compensation insurers to suspend payments pending review of the validity of the claim. Respondents have nothing to say about that.

C. *The Merits.* Most of what respondents say about the merits of the due process issue is based on confusing prospective medical care with the payment of bills. This distinction is critical for due process purposes. The Third Circuit's holding extends *Mathews* v. *Eldridge*, 424 U.S. 319 (1976), far beyond its traditional application, where a plaintiff suffers a direct deprivation, to a challenged practice that directly affects only a third party supplier to the plaintiff. The significant due process issue presented by this case is whether *Mathews* applies to conduct that, at best, has an indirect and uncertain effect on the private interests of the plaintiff.

Respondents claim that we mischaracterize the case as a mere dispute over bills, when it really involves decisions to cease future medical treatment. This assertion is contradicted by the very text of the statutory provision struck down by the Third Circuit, which applies only to bills received for medical treatment already provided: "[a]ll payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)." 77 Pa. Cons. Stat. Ann. § 531(5) (West 1997). Thus, it is not petitioners who "characteriz[e] the dispute as one over 'bills'" (Opp.9); the statute itself uses this terminology.

Respondents assert that a delay in payment of medical bills is tantamount to a cessation of medical care. See Opp. 28 ("Unless

the doctor or other medical provider agrees to work gratuitously, once payments stop, so does the treatment") (footnote omitted). But the prospect of utilization review does not mean that providers must provide health care "gratuitously." Any medical provider who is in compliance with "generally accepted treatment protocols" (34 Pa. Code § 127.467) can expect to be paid in full, with interest, in approximately 70 days. Only those providers who are aware that their treatment is unlikely to be deemed reasonable and necessary by a disinterested professional in their own specialty will have reason to cease treatment. And even then, an employee may choose to pay out-of-pocket for continued care and would later be reimbursed if that treatment were found to be reasonable and necessary.[5] Contrary to respondents' description of the facts of the case (see Opp. 1 ("Respondents all are injured workers who have had their medical benefits stopped"); *id.* at 2 (respondents "were ten individuals who have had their medical benefits stopped through a request for utilization review")), at least six of the ten named respondents continued to receive medical care for some period of time after an employer or insurer petitioned for utilization review and suspended payment, C.A. App. A99, A100, A105, A107, A108, A113. In this respect, workers' compensation insurance works in the same way as any other fee-for-service insurance system. No one claims that a patient is "denied medical care" because his bill may be investigated prior to payment by the insurance company. The real targets of utilization review are not the injured workers, but unscrupulous medical care providers who provide unnecessary and unreasonable services to workers.

Respondents also assert that compliance with the Third Circuit's decision can be accomplished "without significant difficulty or expense." Opp. 4; see also *id.* at 24. Actual experience is to the contrary. The primary impetus for the 1993 legislative reforms was the extraordinary rise in the cost of medical coverage under workers' compensation after the decision in

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[5] Although a provider denied reimbursement under the Workers' Compensation Program may not subsequently attempt to collect from the employee, see 77 Pa. Cons. Stat. Ann. § 531(7), the employee is not prohibited from contracting for care that falls outside the statutory scheme. At least one of the respondents did precisely that. See C.A. App. A113.

Baksalary (a similar decision under a prior version of the statute). After the *Baksalary* court held that workers' compensation insurers could not suspend benefit payments pending administrative review, the number of documented cases of payments for unnecessary and unreasonable medical bills rose from $1.6 million to over $25.2 million — an increase of 1500%. D. BALLANTYNE & C. TELLES, WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY 39 (1991); D. BALLANTYNE, REVISITING WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY 72 (1997). Of the cases submitted to utilization review, even with a statutory presumption in favor of payment, some 67% of disputed bills have been found to be unreasonable or unnecessary in whole or in part. Letter from Timothy Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Pennsylvania Bureau of Workers' Compensation (July 1, 1993) (reproduced in Appendix to the *Amicus Curiae* Brief of American Insurance Ass'n, et al.) Because insurers cannot by law recover payments of these bills once made, the ruling below would have a dramatic effect on the cost of Pennsylvania's workers' compensation system.

The importance of this case, both for the workers' compensation system and for analogous health care payment systems under state and federal law, is underscored by the broad array of parties who have filed *amicus curiae* briefs urging the Court to take this case for review. This puts into perspective respondents' plea (Opp. 7) that certiorari should be denied because the decision below will have no impact outside of the workers' compensation scheme in the Commonwealth of Pennsylvania.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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